Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COVENANT MEDICAL CENTER
3615 19TH STREET
LUBBOCK TX 79410

Respondent Name

STANDARD FIRE INSURANCE CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-10-3378-01

MFDR Date Received

JUNE 22, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Workers' Compensation fee schedule effective March 1, 2008 **excludes** acute rehabilitation services from the Inpatient Prospective Payment System and pays such services at a **'fair and reasonable rate'**…Covenant Medical Center interprets fair and reasonable payment at **100% of Billed Charges**."

Requestor's Supplemental Position Summary Dated January 24, 2013: "We are submitting this correspondence to clarify that (1) an applicable contract, through the First Health Network, is in play with the Standard Fire Insurance Company (SFIC); (2) the contract calls for reimbursement at 95% of the state fee schedule, the contracted rates, or 75% of billed charges, whichever is lesser; and (3) the claim is underpaid because SFIC applied the DRG-based state fee schedule, despite the fact that the service (at Covenant's Inpatient Rehabilitation Facility) is specifically exempt from the state fee schedule. We request the DWC inform SFIC of their error and mandate the claim be paid according to the alternate options provided for by the contract."

Amount in Dispute: $79,236.97

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier reviewed the DRG code (945)) submitted by the Provider. The Carrier then calculated the reimbursement under Medicare for DRG code 945 in the inpatient setting. Using the Division of Workers' Compensation conversion factor of 143% for inpatient services, the Carrier calculated a base 'reimbursement amount comparable to the Division's adopted inpatient fee schedule amount. The Carrier then applied the PPO contract between the Carrier and the Provider to reduce the calculated reimbursement pursuant to the terms in the contract. The Carrier arrived at a total 'fair and reasonable' reimbursement amount of $9,541.89 based on these calculations…As the Carrier has reimbursed the Provider consistently with the methodology outlined above in conjunction with the contracted fee arrangement between the Carrier and the Provider, the Carrier contends this appropriately reflects 'fair and reasonable' reimbursement as required by Rule 143.1 The Carrier contends the Provider is not entitled to additional reimbursement."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
September 30, 2009 through October 16, 2009	Inpatient Rehabilitation Hospital Services	$79,236.97	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.307, effective May 25, 2008, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404, effective March 1, 2008, provides for the reimbursement guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §133.4 effective July 27, 2008, sets the guidelines for notification on contractual agreements.
4. 28 Texas Administrative Code §134.1, effective March 1, 2008, sets forth general provisions related to medical reimbursement.
5. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1-Workers compensation state fee schedule adjustment. Re-priced in accordance with the DRG rate.
   - 18-Duplicate claim/service these services have already been considered for reimbursement.
   - 45-Charge exceeds fee sch/max allowable or contracted/legislated fee arrangement bill has been reviewed/repriced in accordance with your fee for svc contract with First Health.

Findings

1. The insurance carrier reduced disputed services with reason code *"45."* Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on September 30, 2010, the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §134.404(a) states "Applicability of this section is as follows. (1)This section applies to medical services provided in an inpatient acute care hospital with an admission date on or after March 1, 2008."

   28 Texas Administrative Code §134.404(b)(1) states "'Acute care hospital' means a health care facility appropriately licensed by the Texas Department of State Health Services that provides inpatient and outpatient medical services to patients experiencing acute illness or trauma."

   The requestor provided inpatient rehabilitation services; therefore, the guidelines of 28 Texas Administrative Code §134.404 are not applicable.
3. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(f), which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to

ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

5. Former 28 Texas Administrative Code §133.307(c)(2)(G), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

   - The requestor's position statement asserts that "Covenant Medical Center interprets fair and reasonable payment at **100% of Billed Charges**."
   - The requestor did not submit documentation to support that 100% of billed charges is fair and reasonable.
   - The requestor does not discuss or explain how 100% of billed charges supports the requestor's position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
   - The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

     > A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.

     Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - In the alternative, the requestor seeks reimbursement of 75% of billed charges based upon a contractual agreement. As stated above, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		12/17/2013
Signature	Medical Fee Dispute Resolution Officer	Date
		12/17/2013
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.